TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
BAYLOR SURGICAL HOSPITAL

Respondent Name
TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number
M4-14-1960-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
March 04, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Our office is in receipt of your Explanation of benefits dated 01-29-2014 denying our corrected claim as a duplicate billing. Please see the accompanying:

- Corrected claim
- Medical documentation regarding authorization."

Amount in Dispute: $23,058.42

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The following is the carrier's statement with respect to this dispute of 10/22/2013 to 10/25/2013. The requestor provided inpatient surgical services to the claimant on the dates above and then billed Texas Mutual for this. Upon receipt of the bill Texas Mutual reviewed the billing, documentation, and the preauthorization, and determined the surgery was not preauthorized as an inpatient admission. (Attachment) Because the procedure was preauthorized as an outpatient procedure, Texas Mutual declined to issue payment."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 22, 2013 through October 25, 2013	Inpatient Hospital Service	$23,058.42	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 Texas Administrative Code §134.600 sets out the procedures for preauthorization, concurrent utilization review, and voluntary certification of healthcare.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - CAC-W1 – Workers Compensation State Fee Schedule Adjustment
   - CAC-18 – Exact duplicate claim/service
   - CAC-97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
   - 217 – The value of this procedure is included in the value of another procedure performed on this date
   - 224- Duplicate charge
   - 305 – The implant is included in this billing and is reimbursed at the higher percentage calculation
   - CAC-W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal
   - CAC-18 – Exact duplicate claim/service
   - CAC-197 – Precertification/authorization/notification absent
   - 240 – Preauthorization not obtained
   - 350 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal

Issues

1. Did the requestor obtain preauthorization for the disputed services?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code CAC-197 – "Precertification/authorization/notification absent" and 240 – "Preauthorization not obtained".

   28 Texas Administrative Code §134.600(p) requires that "Non-emergency health care requiring preauthorization includes: (1) inpatient hospital admissions, including the principal scheduled procedure(s) and the length of stay."

   Review of the submitted information finds that the services in dispute did not obtain preauthorization for the inpatient admission stay in accordance with 28 Texas Administrative Code §134.600(p). Per insurance carrier response dated March 21, 2014 finds the requestor received preauthorization for the outpatient procedure but no preauthorization for inpatient stay. Additional reimbursement cannot be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	5/29/15 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.